

BEFORE THE OKLAHOMA BOARD OF NURSING

IN THE MATTER OF DAWN MARIE SMITH RONSPIEZ KARLIN, R.N./APRN-CNM/l.p.n.
LICENSE NO. R0076671 SINGLE-STATE LICENSE
LICENSE NO. L0045375 SINGLE-STATE LICENSE (LAPSED)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

This matter comes on for hearing before the Oklahoma Board of Nursing ("Board") on the 8th day of November 2018, at the Sheraton Oklahoma City Downtown, 1 North Broadway Avenue, 2nd Floor Ballroom, Oklahoma City, Oklahoma. A quorum of members was present pursuant to 59 O.S. § 567.4(E).

The Complainant is represented by Debbie McKinney, Esq. and Dawn Marie Smith Ronspiez Karlin, R.N./APRN-CNM/l.p.n. ("Respondent") appeared in person with counsel, James M. Barber, Esq. at the hearing on this date.

The Board, after reviewing the pleadings, hearing and considering all of the evidence and being fully advised, finds by clear and convincing evidence and enters the following Findings of Fact, Conclusions of Law and Order ("Order").

JURISDICTION

This Order is issued pursuant to the Oklahoma Nursing Practice Act, 59 O.S. § 567.1, *et seq.*

FINDINGS OF FACT

The Board after hearing all the evidence presented hereby issues the following Findings of Fact established by clear and convincing evidence.

1. Proper notice of this hearing and the Complaint has been served on Respondent as required by law.

2. Respondent is licensed to practice registered nursing in the State of Oklahoma, and is the holder of a single-state license, License No. R0076671 issued by the Board. Respondent is licensed by the Board as an advanced practice registered nurse-certified nurse midwife. Respondent is nationally certified to practice as a Certified Nurse-Midwife, Certification No. CNM0172 (expiration date December 31, 2020). Respondent is licensed to practice licensed practical nursing in the State of Oklahoma and is the holder of a single-state license, License No. L0045375. Respondent's licensed practical nurse license lapsed on January 1, 2004. The Respondent's licensing history is attached to the Complaint and incorporated by reference as if set forth in full herein.

3. On August 13, 2018, Lisa Griffiths, R.N., Nurse Investigator for the Board, filed a Complaint against Respondent's single-state licenses to practice registered nursing and as an advanced practice registered nurse-certified nurse midwife¹ alleging facts that constitute violations of the Oklahoma Nursing Practice Act. The Complaint is incorporated by reference as if set forth in full herein.

4. On August 24, 2018, the Board received Respondent's Response and Notice of Appearance. The Response and Notice of Appearance are incorporated by reference as if set forth in full herein.

5. The Respondent, while working as an advanced practice registered nurse-certified nurse midwife ("APRN-CNM") for Moments of Bliss Midwifery Services, LLC in Weatherford, Oklahoma ("Midwifery"), failed to adequately care for Patient #1 and Patient #3 and their unborn babies and conform to the minimum standards of acceptable nursing practice as an APRN-CNM² exposing Patients, described *infra*, to avoidable risk of harm.

¹ Respondent initially obtained prescriptive authority on September 13, 2010 from the Board. On January 9, 2014 prescriptive authority was placed on inactive pursuant to Respondent's request. (Page 5 attached to the Complaint)

² The Oklahoma Nursing Practice Act 59 O.S. §567.3a.9. states: "Nurse-midwifery practice" means providing management of care of normal newborns and women, antepartally, intrapartally, postpartally and gynecologically, occurring within a health care system which provides for medical consultation, medical management or referral, and is in accord with the standards for nurse-midwifery practice as defined by the American College of Nurse-Midwives;" See also, 59 O.S. §567.3a.8.

- a. On or about April 11, May 5, June 2, July 1, 20, 28, August 24, September 22, October 17, November 3, 4, 5, 6 and 7, 2016 the Respondent provided midwifery care for Patient #1³ and her unborn baby and failed to: timely perform assessments, perform complete assessments, timely document assessments, adequately and appropriately monitor, follow the agreed terms in the Respondent's *Consent/Waiver for Vaginal Birth After Cesarean (VBAC)* ("Consent") executed prenatally on June 2, 2016 by the Respondent and Patient #1⁴ and timely transfer Patient #1 and her unborn baby to inpatient hospital care. On or about November 7, 2016 Patient #1's unborn baby (Infant-Patient #2) was born⁵ at Mercy Hospital in Oklahoma City, Oklahoma and thereafter the baby was transferred to the University of Oklahoma Medical Center in Oklahoma City, Oklahoma ("Medical Center"). On or about November 8, 2016 Infant-Patient #2 died⁶ at the Medical Center.⁷
- b. On or about May 12, June 9, July 6, August 4, September 9, October 6, 27, November 10, 23, December 5, 15, 22, 29, 2016, January 3, 10, 16, 17 and 18, 2017 the Respondent provided midwifery care for Patient #3 and her unborn baby and failed to: timely perform assessments, perform complete assessments, timely document assessments, adequately and appropriately monitor, and timely transfer Patient #3 and her unborn baby to inpatient hospital care⁷. On January 18, 2017 Patient #3's baby was born as a stillbirth at INTEGRIS Southwest Medical Center in Oklahoma City, Oklahoma ("Hospital").

6. Lisa Griffiths, RN, Nurse Investigator testified she met with the Respondent for an investigative conference on April 4, 2018 ("conference"). Ms. Griffiths testified that during the conference the Respondent described her private midwifery practice, Moments of Bliss Midwifery Services, as having two clinics with one clinic in Weatherford, Oklahoma where the Respondent lives and a second clinic in Oklahoma City, Oklahoma. During the conference, the Respondent stated

³ Patient #1's first delivery was via cesarean section on July 27, 2015; approximately 15 months prior to the delivery of Patient #1's first baby on November 7, 2016.

⁴ The executed Consent terms, included in relevant part: "Contraindications of VBAC outside the hospital are: Classical uterine incision, multiple gestations, more than 2 previous cesarean sections, less than two years (at the time of birth) since cesarean, major uterine surgery, poor health, breech or those that are unwilling to assume the added risks associated with a VBAC labor for themselves and/or baby." The Consent is attached as page 27 and made a part hereof.

⁵ Patient #1 was 36 weeks, and 5 days gestation when Infant-Patient #2 was born unresponsive, who presented with an unstable fetal lie to include a footling breech. The Infant-Patient #2 was resuscitated with Apgar scores of 0 at 1 minute and 1 at five minutes after birth. Apgar testing is the assessment of the newborn rating color, heart rate, stimulus response, muscle tone, and respirations on a scale of zero to two, for a maximum possible score of 10. Apgar testing is usually performed twice, first at one minute and then again at five minutes after birth.

⁶ The Oklahoma State Department of Health death certificate documents Infant-Patient #2's cause of death on November 8, 2016: "Hypoxic Ischemic Encephalopathy".

⁷ The Board received the reports of Oklahoma Nursing Practice Act violation(s) and patient(s) records in spring of 2018.

she requires the birth mother to hire an assistant for the home and/or birth center delivery and to purchase a birth kit containing personal protective equipment, clamps, scissors and towels. During the conference, the Respondent stated she provides the following equipment for home and/or birth center delivery: vital sign equipment, oxygen, oxygen tubing and a Doppler. During the conference, the Respondent stated she does not use a fetal heart monitor for her deliveries. (Testimony of Lisa Griffiths)

Ms. Griffiths testified the Respondent stated during the conference that Patient #1 went into labor prior to 37 weeks, at approximately 36.5 weeks, and the Respondent instructed Patient #1 to go to the hospital; however, the Respondent stated that Patient #1 did not want to go to the hospital, resulting in Patient #1 laboring at home for several days. Patient #1's *Consent/Waiver for Vaginal Birth After Cesarean* (VBAC) reads, "I agree that if my midwife feels that consultation, collaboration or referral of care to a physician is in the best interest of mom or baby, I will comply with her recommendation" and was signed by Patient #1 and the Respondent on June 2, 2016. Patient #1's *"Informed Consent Form"*, signed on June 2, 2016 by Patient #1 and the Respondent, provided that Patient #1 would **not** be a candidate for VBAC if the Patient's labor started before 37 weeks, requiring a transfer of care for evaluation. (Testimony of Lisa Griffiths; page 27 attached to the Complaint; pages 47 and 142 of State's Exhibit "1")

Ms. Griffiths testified that the Respondent, during the conference, stated that while providing nursing care during labor for Patient #3 the Respondent was not able to find fetal heart tones with her Doppler; therefore, the Respondent called 911 as she was worried about abruption. Ms. Griffiths testified Patient #3's baby was delivered at INTEGRIS Southwest Medical Center in Oklahoma City, Oklahoma on January 18, 2017 via an emergency cesarean, was a fetal demise and there was a complete abruption. In May 2016 Patient #3 and Respondent signed a *Consent for Care* and

Informed Consent Form and on October 6, 2016 Patient #3 and Respondent signed a *Consent/Waiver for Vaginal Birth After Cesarean* (VBAC). (Testimony of Lisa Griffiths; pages 408, 409 and 424 of State's Exhibit "1")

7. Complainant called Nancy Bishop, M.D., an obstetrician with approximately 28 years of obstetric experience currently working full-time at Mercy Hospital in Oklahoma City, Oklahoma as a Laborist caring for high risk deliveries. Dr. Bishop testified she was called to assess Patient #1 in the obstetrics triage area of Mercy Hospital as the triage registered nurse could not find fetal heart tones for Patient #1's unborn baby (Patient #2). Dr. Bishop testified she also was not able to find fetal heart tones for Patient #1's unborn baby via ultrasound and when she performed a vaginal exam of Patient #1, the Patient's cervix was fully dilated and Patient #2's arm and knee were the presenting body parts. Patient #1 told Dr. Bishop she had recently felt fetal movement. Dr. Bishop testified she performed an emergency cesarean on Patient #1 with the hope that Patient #2's heart had just stopped and the baby could be saved. Dr. Bishop testified that during the cesarean delivery she visualized thick meconium and green staining with Patient #2 having a nuchal cord wrapped five times around the neck. Dr. Bishop testified Patient #2's Apgar Scores were 0 and 1. Dr. Bishop testified Patient #2 was resuscitated, transferred to the OU Medical Center and subsequently died. Dr. Bishop testified this cesarean was very difficult as Patient #2 was wedged in Patient #1 causing the removal of Patient #2 to be very difficult. Dr. Bishop testified a VBAC should only be considered if the fetal head is the presenting part; i.e., vertex presentation. Dr. Bishop testified that during a patient's labor a Doppler is only a "snapshot" of the baby and the electronic fetal monitor is a "movie" of the baby. Dr. Bishop testified her concerns for the Respondent's nursing care of Patient #1 included that Patient #1 labored at home for several days, had a history of a previous cesarean less than two years prior to this birth and the non-vertex position of Patient #2 prior to birth was not

identified by the Respondent. Dr. Bishop testified she handles a patient's refusal of recommended care by educating the patient about risks and benefits. Dr. Bishop testified that she visited briefly with Respondent after Patient #1's cesarean delivery and Respondent showed no remorse. Dr. Bishop testified that based on her decades of obstetric experience Patient #2 would have lived if Respondent had taken timely and appropriate actions with Patient #1. (Testimony of Nancy Bishop; pages 247, 249, 253 of State's Exhibit "1")

8. Complainant called Melanie Ware, DNP, ARNP-CNM as an expert witness who testified she reviewed medical records for Patients #1, #2 and #3, certificate of death for Patient #2 and certificate of stillbirth for Patient #4 provided by Board staff prior to her testimony at the Hearing. Dr. Ware testified she prepared State's Exhibit "2" after she reviewed the medical records of Patients #1 and #3. Dr. Ware testified that she has performed just under 2000 deliveries, to include approximately 200 home deliveries, with her last delivery in 2015. Dr. Ware testified she has performed VBACs in a hospital only, and that the American College of Obstetrics and Gynecology ("ACOG") has a list of criteria for VBAC to include: age of patient, length of time since last cesarean, and health conditions. Dr. Ware testified the nurse midwife is not committed to a VBAC until delivery, as multiple factors need to be revisited at least every trimester. Dr. Ware testified the nurse midwife is responsible for the oversight of and delegation to the birth assistant; and the nurse midwife needs to be on-site for a VBAC delivery. Dr. Ware testified Patient #1 was **not** a VBAC candidate for multiple reasons to include age greater than 30 years, less than 18 months since previous cesarean, evolving pre-eclampsia, and previous baby weighing more than 10 pounds. Dr. Ware testified Respondent did not comply with her *Consent/Waiver for Vaginal Birth After Cesarean (VBAC)* with Patient #1. Dr. Ware testified Respondent did not timely perform assessments, did not perform complete assessments, did not adequately and appropriately monitor, and did not timely document nursing care

provided for Patient #1. Dr. Ware testified that a nurse midwife is responsible to explain the potential risks to mother and baby in a way the patient can understand and make decisions in the best interest of both mother and baby. Dr. Ware testified there was unnecessary delay in Patient #1 transferring to a hospital as the documentation provides that the birth assistant, Brandy Harris, was managing Patient #1's labor and Respondent should have been with Patient #1. Dr. Ware testified that Respondent's texting with Patient #1's husband during Patient #1's labor about baby poop in the tub, was a waste of valuable time. Dr. Ware testified Respondent's nursing care for Patient #1 and her unborn baby (Patient #2) was below the minimum standard of care and contributed to Patient #2's death. (Testimony of Melanie Ware; pages 6, 7, 8, 17, 47, 103, 104, 127, 128 of State's Exhibit "1"; State's Exhibit "2")

Dr. Ware testified Respondent did not perform timely assessments, did not perform complete assessments, did not adequately and appropriately monitor and did not timely document nursing care provided for Patient #3. Dr. Ware testified Patient #3 had signs and symptoms of evolving preeclampsia that were not addressed by the Respondent. Dr. Ware testified Patient #3 was 41 weeks at the time of her labor and the rate of stillbirth increases by 50% after 40 weeks in a normal delivery. Dr. Ware testified that Patient #3 should **not** have been considered for a VBAC delivery. Dr. Ware testified there is no justification for the documented delay from 2:13 a.m. when Respondent was not able to auscultate fetal heart tones for Patient #3's unborn baby until 2:22 a.m. when 911 was called. Patient #3 was transported via EMSA to the Medical Center where Patient #4 was delivered via cesarean and was stillborn. Dr. Ware testified Respondent's nursing care for Patient #3 and her unborn baby (Patient #4) was below the minimum standard of care and contributed to Patient #4's death. (Testimony of Melanie Ware; pages 368, 369, 370, 371, 372, 373, 374, 375, 387, 388, 389, 390, 391, 408, 409 of State's Exhibit "1"; State's Exhibit "2")

9. Respondent called Michelle Brunnabend, D.O., an obstetrician working for Mercy Health in Oklahoma City, Oklahoma, who testified that at-home deliveries are safe for low-risk births, and that she respects a patient's autonomy to choose where and how to deliver. Dr. Brunnabend testified she performs VBAC deliveries where the mothers are monitored almost continuously. Dr. Brunnabend testified that she would not recommend a VBAC for patients who do not meet criteria for VBAC, and that she would have an in-depth conversation with patients about the risks. Dr. Brunnabend testified that she has acted, unofficially, as a consulting physician for the Respondent and has no concerns with the Respondent's nurse midwife care and/or documentation. (Testimony of Michelle Brunnabend; page 47 of State's Exhibit "1")

10. Respondent called Peggy Cobb, APRN-CNM, a certified nurse midwife in private practice, who testified that she has been a certified nurse midwife for 12 years, and that she has performed about 2,700 deliveries, and that she has performed at-home VBACs. Ms. Cobb testified that if her patient refuses to go to the hospital, Ms. Cobb counsels the patient, continues to contact them, goes to see the patient and documents all of her actions. Ms. Cobb testified that she does not allow birth assistants to manage labor for her patients. Ms. Cobb testified that she did not participate in the peer review by the Oklahoma Midwives Alliance of Respondent's nursing care for Patients #1 and #3. Ms. Cobb testified that she was present for the sharing of the results of the peer review. Ms. Cobb testified that the results of the peer review did not include discussion of Respondent's documentation or discussion of Respondent's birth assistants administering medications; however, the results did include that the delivery of Patient #1's baby was less than 24 months since previous cesarean. Ms. Cobb testified that the overall result of the peer review was the Respondent met guidelines of practice. (Testimony of Peggy Cobb)

11. Brandy Harris, certified birth doula (non-medical) and midwife assistant, testified for the Respondent that she has worked with the Respondent for five years. Ms. Harris testified that in her work with the Respondent she takes vital signs, documents in patient medical records, performs cervical examinations, and administers medications, including Rocephin mixed with Lidocaine intramuscular injections. Ms. Harris testified that the Respondent taught her how to perform cervical examinations and how to administer medications. Ms. Harris testified the Respondent reviews Ms. Harris' documentation in the patient medical records and then signs off on the documentation; however, the Respondent is not present when all of the care is provided by Ms. Harris. Ms. Harris testified that she is hired by the birth mother. Ms. Harris testified that she was hired by and provided care for Patient #1, with and without the Respondent being present. Ms. Harris testified that she was present when Patient #1 signed her consent forms with the Respondent. (Testimony of Brandy Harris; pages 9, 99, 118, 119, 120, 122, 123, 129 of State's Exhibit "1")

12. Respondent testified that she is a certified nurse midwife, a nationally certified professional midwife, and that she has performed approximately 850 births with approximately 350 of those births being outside the hospital. Respondent testified that her patients are provided the consent forms for review prior to signing, and that the Respondent goes through all of the consent forms with the patients prior to signing. Respondent testified that she reviews with each patient each bullet point on the consent forms, including reviewing the 18 months contraindication for VBAC. Respondent testified that she and Patient #1 agreed to the exception that Patient #1 could be at 18 months post-cesarean when she delivered; however, Respondent admits that she did not document the exception in the Patient's medical record. Respondent testified that she did not consider Patient #1 high-risk. Respondent testified that she personally administered the Rocephin to Patient #1, and that Ms. Harris did not administer Rocephin to Patient #1. Respondent testified that she does not delegate the

administration of prescription medications. Respondent testified that Patient #1 was not in active labor at the time Respondent assessed Patient #1 when she refused to go to the hospital for evaluation. Respondent testified that had Patient #1 been in active labor at the time she assessed the Patient, Respondent would have performed her routine monitoring. Respondent testified that upon Patient #1's refusal to go to the hospital, Respondent explained the issues to Patient #1. Respondent testified that Patient #1 has the autonomy to make her own decisions. (Testimony of Respondent; pages 3, 7, 8, 16, 17, 31, 47, 124, 127, 128 of State's Exhibit "1")

Respondent testified that Patient #3 was also a VBAC patient who desired a home birth. Respondent testified that she was first concerned about Patient #3 when she was unable to hear fetal heart tones during the Patient's labor. Respondent testified that she took steps to include having Patient #3 make position changes when she could not hear fetal heart tones prior to directing Patient #3's husband to call 911. Respondent testified that she did not have concerns about Patient #3 with the trace protein in her urine, vaginal discharge, headache, weight gain, blood pressure changes and other assessment changes. Respondent testified that she did not consider Patient #3 high-risk. (Testimony of Respondent; pages 374, 387, 388, 389, 390, 392, 397, 398, 408, 409, 412, 413, 424, 440, 441 of State's Exhibit "1"; State's Exhibit "2")

Respondent testified that she did not make any changes in her nurse midwife practice after her nursing care for Patient #1 and the death of Patient #2. Respondent testified that now she no longer accepts patients for a primary VBAC delivery. Respondent testified that she did not have prescriptive authority at the time she provided nurse midwife care to Patients #1 and #3. Respondent testified that she did **not** have a physician order for the administration of Rocephin to Patients #1 and #3. Respondent testified that she directed the Patients to obtain the Rocephin from their primary healthcare providers. Respondent testified that she continues to administer medications without a

healthcare provider's order. Respondent testified that John Karlin is her husband, and that he is part owner of Moments of Bliss Midwifery. Respondent testified that Mr. Karlin is an advanced practice registered nurse and does not "typically" prescribe Rocephin for the Respondent's patients. Respondent testified that Mr. Karlin does prescribe breast pumps for the Respondent's patients for insurance purposes. Respondent testified that she volunteered for the peer review of her care for Patients #1 and #3 and provided the Patients' medical records to the peer review panel. Respondent testified that she does not have any concerns about her nurse midwife practice. Respondent testified that she is concerned about her documentation, but testified that her documentation is more thorough than others' documentation. (Testimony of Respondent; pages 17, 387, 415 of State's Exhibit "1")

13. In considering the factors for the imposition of an administrative penalty, pursuant to 59 O.S. § 567.8(A)(2) and (J)(1) & (2), the Board finds that in addition to the violation(s) of the Oklahoma Nursing Practice Act by Respondent, the Board has considered those factors set forth in O.A.C. 485:10-11-2(c) of the Rules promulgated by the Oklahoma Board of Nursing, and relies specifically on Factor Number 1: evidence of actual or potential harm to patients, clients or the public; Factor Number 2: the seriousness of the violation, including the nature, circumstances, extent and gravity of any prohibited acts, and the hazard or potential hazard created to the health, safety and welfare of the public; Factor Number 3: evidence of misrepresentation(s) of knowledge, education, experience, credentials or skills which would lead a member of the public, an employer, a member of the health-care team, or a patient to rely on the fact(s) misrepresented where such reliance could be unsafe; Factor Number 4: evidence of practice history; Factor Number 5: evidence of present lack of fitness; Factor Number 8: the actual damages, physical or otherwise resulting from the violation; Factor Number 9: the deterrent effect of the penalty imposed and Factor Number 13: evidence of a lack of truthfulness or trustworthiness.

14. The Board finds there was clear and convincing evidence presented at the hearing on this date to support the allegations against the Respondent.

CONCLUSIONS OF LAW

1. The Board has jurisdiction to hear this matter pursuant to 59 O.S. § 567.1, *et seq.* and O.A.C. 485:10-11-1, *et seq.*, of the Rules promulgated by this Board.

2. The Board concludes that Respondent failed to adequately care for patients or to conform to the minimum standards of acceptable nursing practice that, in the opinion of the Board, unnecessarily exposed a patient or other person to risk of harm, which is in violation 59 O.S. § 567.8(B)(3) as defined in the Rules promulgated by the Board, specifically, O.A.C. 485:10-11-1(b)(2), is guilty of acts that jeopardized a patient's life, health or safety, which is in violation of 59 O.S. § 567.8(B)(8), as defined in the Rules promulgated by the Board, specifically, O.A.C. 485:10-11-1(b)(4)(D), and is guilty of unprofessional conduct, which is in violation of 59 O.S. § 567.8(B)(7) as defined in the Rules promulgated by the Board, specifically, O.A.C. 485:10-11-1(b)(3)(H).

3. Based on the evidence presented, the Board finds that Respondent's conduct is grounds to deny, revoke, suspend or discipline Respondent's license, to otherwise discipline applicants, to impose an administrative penalty, and to recover the costs of the investigation, all as provided in 59 O.S. § 567.8(A)(1), (2) & (3), (J)(1) & (2), (L) and (M), with reliance specifically on O.A.C. 485:10-11-2(c)(1), (2), (3), (4), (5), (8), (9) and (13) of the Rules promulgated by the Oklahoma Board of Nursing.

ORDER

IT IS THEREFORE ORDERED by the Oklahoma Board of Nursing that the Respondent's advanced practice registered nurse-certified nurse midwife license in the State of Oklahoma is **revoked for a period of ten (10) years.**

IT IS FURTHER ORDERED by the Oklahoma Board of Nursing that the Respondent's single-state license to practice registered nursing is **revoked for a period of two (2) years** and that Respondent's licenses are disciplined as follows:

1. **Prior to reinstatement**, Respondent shall **pay an administrative penalty** payable to the Oklahoma Board of Nursing in the full amount **Two Thousand Dollars (\$2,000.00)**. Partial payments are not accepted. The administrative penalty shall be paid only by certified check and/or money order. Any application to reinstate Respondent's license(s) after revocation shall not be considered until the administrative penalty is paid in full.
2. **Prior to reinstatement**, Respondent shall **pay the cost of the investigation and prosecution** of the disciplinary action payable to the Oklahoma Board of Nursing in the full amount of **Six Thousand Two Hundred Eighty-eight and 18/100 Dollars (\$6,288.18)**. Partial payments are not accepted. The investigation costs shall be paid only by certified check and/or money order. Any application to reinstate Respondent's license(s) after revocation shall not be considered until the costs of the investigation are paid in full.

IT IS FURTHER ORDERED that Respondent shall comply in all respects with the Oklahoma Nursing Practice Act, 59 O.S. § 567.1, *et seq.*, with the Rules of the Board found at Oklahoma Administrative Code Title 485 Chapters 1 and 10 and Guidelines relating to nursing education, licensure and practice, and this Order.

IT IS FURTHER ORDERED that this Order will be sent to Respondent at Respondent's most recent address of record on file with the Board. If this Order is returned with a notation by the United States Postal Service indicating that it is undeliverable for any reason, and the records of the Board indicate that the Board has not received any change of address since the Order was sent, this

Order and any subsequent material relating to the same matter sent to Respondent's most recent address on file with the Board shall be deemed legally served for all purposes.

IT IS FURTHER ORDERED that this Order shall become final after anticompetitive review and a determination by the Oklahoma Attorney General that the Order is in compliance with the Board's authority and mission to protect the public health, safety and welfare, and Respondent has been legally served with this Order as set forth in this Order.

IT IS FURTHER ORDERED that this Order constitutes disciplinary action by the Board and may be used in any subsequent hearings by the Board. In the event other misconduct by Respondent is reported to the Board, this Order may be used as evidence against Respondent to establish a pattern of behavior and for the purpose of proving additional acts of misconduct.



AG:ad

OKLAHOMA BOARD OF NURSING

By:

Carmel Dickel, RN
Presiding Board Officer